BOSTON UNIVERSITY
SCHOOL OF SOCIAL WORK

THE USE OF PSYCHIATRIC HELP IN A MEDICAL CHILD PLACING AGENCY

A Thesis

Submitted by

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CHAPTER I

INTRODUCTION

As social work developed, the use of psychiatric help became more common as a part of the social treatment. Social work itself aims at a prevention of mental illness. Also, social work takes part in the treatment of mental illness. On some occasions, case-work is not sufficient and it is necessary to obtain psychiatric help in the course of the treatment. If psychiatric treatment is secured, however, the social treatment is not withdrawn, but on the contrary intensified. A close cooperation exists then between psychiatry and social work.

Also, the science of psychiatry has developed to such an extent that there is much less prejudice towards the practice of it due to an increased understanding of its principles by lay people. Also, this form of treatment is far more accessible than in years past.

The main obstacle in obtaining this type of treatment for many people is now financial rather than intellectual, and there are gradually more opportunities for the masses to profit by psychiatric treatment. This has been furthered by the establishment of more child guidance clinics, more psychiatric clinics in hospitals, and more psychiatric consultants in social agencies.

Although there are now increasing facilities, they are still inadequate. Even though it is not rare for social agencies to obtain the cooperation of child guidance centers or psychiatric clinics, actually the lack of psychiatrists and the lack of a sufficient number of clinics

makes it nearly impossible to work jointly with a psychiatrist on a merely preventive level.

Often psychiatric help is given only when the problem is already deeply rooted. Often it is only when such a problem is recognized in children by the parents, friends or by workers in social agencies that it is referred to a child guidance or other service giving psychiatric consultation. Frequently it is submitted to the inevitable delay of weeks or months, due to the long waiting list of those institutions.

Sometimes a social agency answers the problem by appointing a psychiatrist to its own staff. Often this psychiatrist will work at the agency one or two days a week and provide consultations and discussions of cases with the staff or actually give treatment to some of the clients. This is an ideal arrangement which, of course, is not possible in every agency due to a lack of funds.

Sometimes agencies, such as hospitals, that refer a child to the Children's Mission, have already been aware of the need of the child for psychiatric treatment and therefore have offered this child the opportunity of attending their psychiatric clinic. In such cases, there is a close cooperation between the social services of both agencies involved. The principles implied in this study are generally accepted. The worker will present a variety of situations to show how these principles work or do not work in actual operation.

What is being done in the agencies where no psychiatrist is working on the staff? How do the case workers obtain the psychiatric help needed? Where do they apply? What happens to the clients while waiting for psychiatric help? What happens to those who did not get this help?

These are some of the questions that the writer will try to answer. It is the scope of this study to find out how an agency that has no psychiatric consultant meets the need of psychiatric help for its clients.

For this purpose, the writer chose to study a private agency, the Children's Mission to Children, which is a medical child placing agency. The agency's files on all cases of children who were referred for or actually received psychiatric help during the years 1947 and 1948 were studied. Several tables and a schedule were used for this purpose. Twenty-three cases were found in the files. All of them were studied, but only eleven were illustrated in the study. Those used were chosen as being most representative to the different points discussed in the study.

The twenty-three cases were divided into different groups according to whether they were referred by the Mission for consultation only, or for psychiatric treatment by the Mission, other agencies and both. This groupment was made to illustrate the methods of referral.

Although the work of the Mission is done with both the children and their parents as well, and although it happens sometimes that some other member of the family of a child under the care of the Children's Mission receives casework or psychiatric help as well, it was decided that the case presented in this study would include only the children actually under care of the Mission.

In preparing for the return of a child placed in a foster-home to his family, it happened sometimes that the workers had to refer some mem-

bers of the family to a psychiatrist. Although such work was sometimes handled by the Children's Mission worker exclusively, the case was rare and not sufficiently representative to be included in this study.

Besides a broad study of all the cases referred, a detailed discussion on several representative cases will be given.

The study of the cases chosen for analysis will be limited to the method of referral to psychiatric agencies and the acceptance of the cases by those agencies. No attempt will be made to evaluate the work done by the psychiatrist nor the results obtained.

CHAPTER II

THE AGENCY---HISTORY AND FUNCTION

The Children's Mission to Children was founded in 1849 when a little girl by the name of Fannie Merrill became interested in founding a club to help poor children. The club became the Children's Mission. Funds were raised by children in Sunday Schools, and even today it is a tradition to raise money in certain Sunday Schools in the Boston area at Easter time, so that actually a part of the Mission's budget is still given by children.

In the early days of its development, the Children's Mission was primarily concerned with keeping neglected children out of the streets as indicated by the following passage in one of its early reports:

> To create a special mission to the poor, ignorant, neglected children of this city; to gather them into day and Sunday schools; to procure places and employment for them; and generally, to adopt and pursue such measures as would be most likely to save or rescue them from vice, ignorance, and degradation.[1]

The measures to be taken were not clearly set forth, nor was the phrase "poor, ignorant neglected" properly defined. At that time social work was negligible and little differentiation was made between the care of children and adults. Children mingled with adults in poor houses, almshouses and jails. The Children's Mission was one of the very first agencies to specialize in social work with children.

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1 William Crosby, Superintendent's Annual Report, May 1899. "The Fiftieth Annual Report of the Children's Mission to the Children of the Destitute," p.11.

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philanthropist, inaugurated the idea of sending groups of children from New York and New England to live on farms in the Middle West.

When this children's emigration was given up, the program of foster homes in the place of residence of the children was started. But this program did not produce good results and the system of placing children in institutions was favored. Modern ideas of child care began to take shape at the turn of the century. In the early 1900's, foster home placement was again favored and case work treatment was developed by Mary Richmond. This meant that the child was more carefully fitted to the home, his problems more carefully studied and a greater attempt made to individualize the problem. Due to this, child placement in foster homes became much more satisfactory than it had been when tried earlier and has survived as the present day method of choice in the treatment of children who cannot be cared for in their own homes.

As early as 1914, the Children's Mission showed application of modern trends of social work - as described in the following report:

> Foster homes are most carefully selected, and approved and classified as the special type of child to be received. We usually pay board for those children not old enough to earn their own way, and keep them under our close control. . . The maintenance of these children is by far the heaviest item in the annual budget, though the whole number thus cared for this year (301) was less than 40 per cent of the children helped.
>
> The remaining 60 per cent were provided for through the Department of Advice and Assistance without the necessity for us to take them. This department receives all applications (during the year, 363, representing 557 children) makes careful study, diagnoses the case and prescribes the remedy.
>
> Almost all who apply ask that the child be received into charge, but it is our plan to contrive that wholesome families be kept

intact, whenever possible, and striking at the cause of the difficulty, we aim at its correction.[2]

It was about that time that the Children's Mission adopted a definite policy of placing medically handicapped children in foster homes as a result of the suggestions made by Doctor Richard C. Cabot, who, while organizing the Social Service Department of the Massachusetts General Hospital, advanced that some children stayed so long in the hospital that they became "institutionalized" and so were retarded in their physical and mental convalescence. He suggested that their recovery would be quicker if they could be cared for in their own homes or in foster homes. This idea was a great advance in methods of caring for sick children.

The Children's Mission gradually took more and more medically handicapped children referred by hospitals for foster home care and for supervision in their own homes. In the Seventy-Sixth Annual Report of 1925, this work of the agency is clearly described:

> During the past year we have dealt with 379 applications, representing the needs of 489 children, and in each instance it has developed upon us to extricate our clients from their entanglements, to see that peculiar needs are met by specialists, and to provide that form of help which we are specially equipped to render.
>
> In our foster homes, where children are cared for under our close supervision, we have provided for 233 children of all ages, and of race and faith without restriction. Here their parents have visited them and we have encouraged return of the children as soon as we were sure that the conditions of both child and home would warrant such a course.

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2 Parker B. Field, "Report of the General Secretary," The Sixty-Fifth Annual Report of the Children's Mission to Children, pp. 13-14.

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> Our methods, in brief, are as follows. First, there is an exhaustive study of the situation and of the child, with object the correction of the difficulty without the removal of the child. If the child must be removed, we take great pains to select from our approved and classified foster homes one of the faith of the child which just fits the particular need. Next comes the placement of the child in its new environment with as little disturbance as possible. Then follow weeks, months, or years of oversight by a devoted visitor who assumes the function of a guardian of the child and friend of the family which may, itself, need rehabilitation. This continues until some time after the child, with the handicap removed, has returned to his own kin.[3]

By 1926 the percentage of convalescent children had increased from thirty-three to forty. In the practice of case work with medically handicapped children and with children of broken families, it was soon evident that most of the children were emotionally disturbed to the point that some of them presented problems with which case workers were not able to cope without the help of a psychiatrist. Therefore, it is not surprising to see that as early as 1927 a psychiatrist was on the staff of the Mission. Unfortunately, it was necessary to discontinue her services because of a lack of funds. The psychiatrist was on the Mission's staff only during the years 1927 to 1930. In 1945 and 1946 the Mission employed a consultant psychiatrist. Unfortunately this psychiatrist left the Agency because she lacked the necessary time. It is inevitable that the Agency suffered a considerable loss by having to discontinue the services of a psychiatrist on its own staff. It would be advisable to have a discussion with a psychiatrist on each case in the care of the

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Mission. For actually, practically all children under care of the Mission come in for medical reasons and therefore are apt to suffer from emotional disturbance due to their illness. This will be discussed more fully in the next chapter.

Since 1930, although there has not been any psychiatrist on the staff, psychiatrists are often asked to come to the Mission to give talks to the staff and contribute to the program of foster mothers' meetings. To answer the need for psychiatric help of certain children under its care, the Mission now cooperates with psychiatric agencies in the community and has done so since 1930.

The initiative for referring cases to the psychiatrist is left in the hands of the case workers, and the number of cases referred depends on the social workers' awareness of severe emotional instability in their clients. Often the reason why convalescent children were referred to the Mission by hospitals instead of being sent home directly, was that their own homes were inadequate and their parents were unable to give them the proper care. Consequently, the children needed to be placed or supervised.

In 1939, the purposes of the Mission were restated in the Ninety-first Annual Report:

> The Children's Mission provides care for children with medical problems from Boston and from any district outside Boston where distance does not make this service impracticable.
>
> Owing to limitations of resources, the Children's Mission is obliged to select carefully those persons most needing help and falling most suitably within its function. It does not limit intake on basis of ability to pay for care except in times of great financial stress.

> This Society particularly serves the hospitals caring for children with promising medical and social outlook. Medical supervision is maintained in part by the hospitals, in part by the Children's Mission.
>
> It provides case work services for children within their own family group, in foster homes, in other institutions, and maintains study projects which will add to insights and methods in the care of children with medical problems.[4]

From this time on, the Children's Mission was recognized among other social agencies as a medical child placing agency. Actually, according to the agency's last statistical reports, very few children were placed for other than medical reasons. An example of such an occurrence might be when a sibling of a child already placed in a foster home has also to be placed for a short time due to an acute illness of its mother. Since the case work in the family has already been done by the Mission, they are the logical agency to do this.

One of the main features of the policy of the Agency is that case work is done with the entire family as well as the handicapped child.[5] Sometimes it appears that the case work with the family is of even greater importance than with the child under care. It is most valuable and logical to prepare the family for the return of their child since the reason why children are referred by hospitals to the Children's Mission instead of the family is because those children need convalescent care that their family is unable to provide. It would be of little use to work with a child alone and not try to remove the very reasons why he

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4 The Children's Mission to Children Ninety-First Annual Report 1939.

5 Mrs. Marie Carden -Thesis 1948 "A Study of Family Case Work in the Children's Mission".

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4 The Children's Mission to Children Ninety-First Annual Report 1932.

5 Mrs. Doris Gordon -Thesis 1948 "A Study of Family Case Work in the Children's Mission".

was unable to go home in the first place. When a child has spent several months in a foster home and is ready to go to his home, it is essential that the family also be ready to receive him. So it is not uncommon that the workers of the Mission try to solve problems of broken homes, behavior problems of siblings, alcoholic and unemployed fathers, neurotic mothers, etc.

The Children's Mission is a private agency and raises its budget mostly on a private basis.[6]

The staff is composed of a general secretary, seven trained case workers, three student workers and one occupational therapist. Four office workers are employed in the Mission.

During the year 1947, a total of 276 children were cared for. In 1947 there were 175 children placed in foster homes and 101 were under supervision in their own homes. The Mission has approximately fifty beds available in foster homes in Boston and the vicinity.[7]

Besides its program of foster home placement, the Children's Mission conducts a program of summer placements. The purpose is to provide summer vacations to handicapped children. These children are referred by medical agencies or are discharged cases from the Mission. The children are usually placed in small groups in foster homes in the country. Camps are not advisable in most cases because these children are limited in activity. For such temporary placement, there is less case work done

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6 The Children's Mission to Children Ninety-Ninth Annual Report 1947.

7 The Children's Mission to Children One Hundredth Annual Report 1948.

with the family because the need to modify the home situation is usually not necessary. The case worker will interpret placement to the child and the parents in order to help the child who is closely tied make the break from his family. Also, the case worker will give the foster parents information concerning the child's illness, his personality and interest, his family relationships and the directions for physical care.

In this short sketch of the history and present aims of the Mission, it has been shown how the Mission evolved from an agency aimed at helping children in general into a specialized agency for placing medically handicapped children in foster homes. Enough has also been said to show that in this work psychiatric help is often needed. The great importance of this problem will now be examined in greater detail.

CHAPTER III

SPECIAL FACTORS INVOLVED IN WORK WITH MEDICALLY HANDICAPPED CHILDREN.

In dealing with medically handicapped children, the case worker must have a deep knowledge of the meaning of illness to the patient, an understanding of psychosomatic concepts, and an awareness of signs of mental disturbances and an ability to recognize abnormal tendencies which, if dealt with early, can be overcome before they take root in the child's mind. Therefore, it is important before discussing cases which workers have referred to psychiatric clinics, to elaborate on the psychosomatic aspect and the psychological factors involved in working with medically handicapped children.

It is felt that often the actual physical disease is less destructive than the emotional damage done to the patient by a poor understanding of that disease and the inadequate reactions of his family to the situation it creates. Too much sympathy and too much shielding may make the child more abnormal psychologically than physically. It is not uncommon that parents react to the illness of their child by fear for him which may result in an oversolicitous attitude which the child may exploit. The child is brought then into a state of regression where he is dependent on others for gratification.

The child's reaction to disease is frequently a reflection of the emotional attitudes of the people around him which he is prepared to accept as an excuse for his own inadequate reactions to his illness. It is important that these attitudes should not be more crippling than the

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degree of illness suffered. It is evident that any chronic illness frequently constitutes a focus of attention and can result in an accentuation or progressive development of a number of attitudes, including dependence on others or an incapacitating fear of illness. Perhaps the worst mistake that can be made, however, is to attempt to hide from the child the fact that he is not like other children. The result of this would be that the child will never grow responsible for following medical advice nor will he submit willingly to his physical restrictions or acknowledge the fact that he has physical handicaps and this will result in his becoming morbidly sensitive about them.[1]

It is of the greatest importance to make the child realize as early as possible that he has a physical handicap which will limit his activities to a certain extent throughout life, because the sooner he faces that fact and tries to make the best of it, the sooner he will begin to adapt his aims and ideals to a life consistent with his physical limitations. Here lies the responsibility of the physician, the parents, the social worker.

The greatest responsibility that the social worker of the Children's Mission faces is to be sure that both the parents and the child have a clear understanding of the child's illness, the physical limitations that it involves and the reasons for them. Often, in families of poor intellectual standards, it is difficult to give much interpreta-

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1 The information was obtained from lecture notes in psychosomatic course.

tion and the worker must simplify the necessary explanations and try to give them illustrative examples of children with the same disease. But in any case, the worker must be sure that the child has the best understanding possible of his illness. For, as Wallin has stated,

> It is well known by working with physically handicapped children that frequently their worst liability is not the physical handicap to which they are subject, but the personality maladjustments which have arisen as a result of their mental reactions to their handicaps.[2]

Illness may be a threat to a child in regard to his security, dreams and ego. According to Bartlett in an article in The Family, "The child is primarily concerned with being restored to his former place in society. For this reason, the question of social incapacity, whether or not it is consciously understood by the patient, is very important."[3]

While the child is placed in the foster home, the worker keeps constantly in mind the need of the child for security. She will watch that the affection given does not exceed a health degree and become overprotective. In general, the worker will be sure that the life led by the child is as close to normal as possible.

As more than half of the children under care of the Mission in recent years have been convalescing from rheumatic fever, the writer will give some special implications connected with this illness. Socio-economic factors appear to influence the disease. Crowded, unhygienic

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2 J. E. Wallace Wallin, "Minor Mental Adjustments in Normal People", Durham, N.C. Duke University Press, 1939, p. 230.

3 Harriet Bartlett, "Emotional Elements in Illness", The Family, April, 1940, pp. 39-47.

living conditions and poor nutrition occur frequently in association with rheumatic fever. Also rheumatic fever tends to be concentrated in certain families which are influenced by psychological factors as well. Often recurrence of rheumatic fever appears in convalescent children when they are emotionally disturbed. Particularly in dealing with rheumatic fever patients the worker must have an adequate knowledge of psychosomatic concepts.[4] Rheumatic fever is one of the causes of disabling heart disease.

Emotional disturbance in a child who has a weak heart may bring about excessive muscle tension of this organ. As Dunbar puts it, "Muscle tension is of fundamental importance as an expression of the personality's habitual defenses."[5] An attack of rheumatic fever might be accompanied by a desire for regression, a need for dependency, a starving for affection and love, a result of fear, guilt or anxiety. It is not always easy to differentiate the causes of illness in a child. When a sick child needs psychiatric help it may be because he has a psychosomatic illness, or it may be necessary because the illness has induced a severe maladjustment to society.

The worker dealing with medically handicapped children must constantly be aware of the psychiatric problems involved. Case work might help the crippled child to avoid developing an abnormal psychology which

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4 Edward Bland, "The Convalescent Care of Children with Heart Disease due to Rheumatic Fever".

5 Flanders Dunbar, "Emotions and Bodily Changes" Third Edition N.Y. Columbia University Press, 1946, p. 29.

might affect his life far more than his actual physical deformities. Still, it happens that children receiving case work need further help of a psychiatrist to develop into normal beings, at least mentally. This might be due to the fact that their problems are already too deeply rooted to be handled exclusively by the social worker. The children referred for psychiatric treatment are then helped jointly by the psychiatrist and the social worker working in close cooperation. However, one must recognize that it also happens that the social workers sometime fail to recognize the psychological reasons underlying the child's maladjustment and ignore the necessity to influence satisfactorily its environmental milieu.

It will be shown in the following chapter that in the Children's Mission trained psychiatric help was sought for many different reasons. In general when used, it was given in conjuntion with case work and was complementary to it.

CHAPTER IV

ANALYSIS OF CASES

Classification of Cases

In order to study the use of psychiatric help in the Children's Mission, a given period was chosen, the two most recent years of 1947 and 1948. In order to give a complete picture of the use of psychiatric help, it was necessary to consider not only the cases that were referred for psychiatric treatment during those years, but also those cases referred previously but using psychiatric help during 1947 and 1948. The cases were considered and studied in order to find out how the case workers recognized the need for psychiatric treatment in the children under their care and how they consulted psychiatrists for advice or referred the children for treatment.

As shown in the following table, twenty-three children were using this help during 1947 and 1948.

TABLE I

NUMBER OF CHILDREN FOR WHICH PSYCHIATRIC HELP WAS USED DURING 1947 AND 1948

Children Using Psychiatric Help	Boys	Girls	Total
Before Jan. 1, 1947 and still using it after this date	2	4	6
After Jan. 1, 1947 and before Jan. 1, 1949	10	7	17
	12	11	23

The records of these twenty-three children were studied, considering particularly the reasons for referral for psychiatric help, the diagnosis of each child at the time of placement with the Mission, and the sources of help used. As shown in the following table, the largest number of children were referred for behavior problems.

TABLE II

REASONS FOR REFERRAL

	No. of Children
Behavior - School difficulty	8
Failure to develop normally	5
Sex difficulty	5
Physical symptoms - enuresis, constipation, sleeplessness, etc.	3
Family misunderstanding - rejection	2
Total	23

The next table shows that the medical diagnosis of the children referred was most frequently the one of rheumatic fever. This is not surprising as more than sixty per cent of all the children cared for by the Mission have, or have had, rheumatic fever.

TABLE III

MEDICAL DIAGNOSIS OF CHILDREN

Diseases	No. of Children
Rheumatic fever and rheumatic heart disease	8
Rheumatic fever	4
Asthma	3
Arthritis	2
Blindness	2
Nephrosis	2
Celiac Disease	1
Rickets deformation	1
	23

Although each of these cases was carefully studied, only eleven will be discussed in full detail as they best illustrate the different points discussed in this chapter.

The ages of the children referred for psychiatric help were pretty well distributed as shown in the following table.

TABLE IV

AGES OF THE CHILDREN REFERRED

Ages	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	Total
Number	2	1	2	3	3	1	2	1	1	1	2	2	1	0	1	23

The psychiatric help given to these twenty-three children during the two years considered consisted of consultations between case workers and psychiatrist to discuss a case or actual referral of children to

psychiatric agencies for treatment

Consultation

The use of consultation will first be discussed and a case will be given as illustration. It was said in the Second Chapter of this study that in the history of the Mission there had been a psychiatrist on the staff before 1930, and that recently the Mission had employed a psychiatrist as consultant. Unfortunately this consultant could not stay on the staff and the Mission did not find someone to replace her. While the psychiatrist was still working for the Mission in 1946, the workers had constant consultation with her concerning most of the children in care.

The six children who obtained psychiatric help before January 1, 1947, and who were still using it after this date had benefitted from the services of the Mission's consultant in 1946 and had been referred according to her advice. After the departure of the consultant, the Mission was unable to obtain as frequently the advice of a psychiatrist concerning the referral of children to psychiatrists. A consultation was sought in very few instances, and then only for very specific reasons when the problem was especially serious. As shown in the following table, there were very few instances of such consultations.

TABLE V

NUMBER OF CHILDREN

Referred by:	For consultation on the case with a psychiatrist	For Psychiatric treatment	Total
Agencies other than the Children's Mission	0	3	3
Children's Mission and other agencies on different occasions	0	2	2
Case workers of Children's Mission	4	14	18
	4	19	23

Among the records of those twenty-three children there were only four cases in which the case worker consulted a psychiatrist to get his advice. This advice was sought from private doctors or from psychiatrists in the clinic attended by the children. Among those four cases for which the case workers had consultations with psychiatrists, the most illustrative one is the case of Jimmy, a rheumatic fever child. In the case of Jimmy, the worker asked the advice of a psychiatrist six months after he was placed with the Mission.

> Jimmy (15) was eight years old when he was placed in a foster home with a diagnosis of rheumatic fever. Jimmy had been seen by a psychiatrist of an out-of-town mental hygiene clinic a few months before his placement with the Mission. He was known to be quarrelsome, had nightmares and walked in his sleep. He showed open jealousy of his sister of five. Jimmy made a good adjustment in the foster home. The worker met his mother only a few times as she lived in Vermont, but there was a close correspondence

TABLE V

NUMBER OF CHILDREN

Referred by:	For examination on the case with a psychiatrist	For Psychiatric treatment	Total
Agencies other than the Children's Mission	0	3	3
Children's Mission and other agencies on different occasions	0	2	2
Case workers of Children's Mission	4	14	18
	4	19	23

between the two. As the worker learned more about Jimmy's background and as he was soon ready to go back home, she realized she needed the advice of a psychiatrist in order to find the best solution to his problems. This was Jimmy's story: Jimmy began to have feeding difficulty at the age of three months due to a change from breast to bottle feeding. He had developed eczema and asthma and was a year old before a suitable formula was found. He became allergic to house dust. About every two months he developed a high temperature, vomited and had mild diarrhea. When he was six, he had an appendectomy and there was a question of rheumatic fever at this time. Insomnia followed the appendectomy. Jimmy complained of being lonesome, and often he came to his mother's room with this complaint. His mother found him several times during the night all dressed and ready to go out. The mother was a nurse and had spent a great deal of time with the boy until she was hospitalized when Peggy was born. Jimmy accused his mother of leaving him all alone. He developed increasing jealousy of his sister. He later had to share his room with her. His father was a very unstable man who was very severe with Jimmy. Jimmy was quite scared of him. There was a great deal of tension at home when Jimmy was an infant as the parents were living with their in-laws and there were several aunts who were constantly vying with each other to take care of him. At home he had the reputation of being naughty and irritable, constantly provoking other children into rages. He showed open hostility toward his sister.

The worker's opinion was that the person who needed help was the mother, since Jimmy had adjusted very satisfactorily to the present foster home. The worker had a conference with a psychiatrist. This doctor decided to see the mother to interpret to her the reason for Jimmy's resort to illness. He felt that Jimmy should not be returned to his home until he had a chance to talk to the mother. He recommended: 1) that the mother separate the children after Jimmy's return 2) that she should have Jimmy take responsibility for himself as much as possible in order to help him gain some maturity 3) also, he thought that the mother should see the worker again.

In this case, the worker found out by her consultation with the psychiatrist, that there was no immediate need for psychiatric treatment for this boy.

It is interesting to notice that in none of the four cases for which the worker asked for a consultation was psychiatric treatment for

the child recommended. The consultations resulted usually in advice in dealing with the children and their environment on a more preventive basis. Obviously, the problems were not serious enough to be considered for psychiatric treatment.

Referrals for Psychiatric Help by Other Agencies

Table V shows that three children were referred to psychiatrists by agencies other than the Mission. Those cases happened particularly when a child had been referred to the Mission by a hospital. The referring hospital had already noticed the need of the child for psychiatric treatment and offered him this treatment in their own clinic.

This was the case of two blind children who were included in a more or less experimental group of blind children receiving psychiatric help at the Massachusetts General Hospital.

> James (14) had been placed in a foster home of the Mission at four years of age because his parents kept him as an infant. He made rapid progress but was sent home after several months because the foster mother would not keep him any longer. He was no longer than a month in his house when he began to regress again. The Massachusetts General Hospital who knew him offered to include him in a group of blind children receiving psychiatric help provided he would be placed in a foster home.
>
> The psychiatric treatment was explained to the parents by the hospital social worker and it was accepted readily by them as they did not feel they could keep the child at home.

Another case was the one of Maggy, a little blind girl of four.

> Maggy (6), a little girl of four, had been in a Mission foster home for two years and had reached a standstill in development. The agency questioned if there was any point in keeping her any longer, but agreed to include her in the above group at the hospital and she was placed in another foster home.

The third case was the one referred for placement by the psychiatric clinic of an hospital. It is evident that at the time of his placement with the Mission, psychiatric treatment had already been considered by the hospital.

> Ronald (22) was an arthritic case who had hardly known his mother as she had divorced his father when he was three years old. He had been placed in an orphanage and then cared for by his grandmother. His father died. He was seven years old when his mother remarried. At that time he was again separated from her for a year. He never adjusted well in his home since then. His mother was quite unstable and disturbed. He developed arthritis and while in the hospital he was seen by a psychiatrist and continued to see one when he was placed by the Mission in a foster home. There was close cooperation of the Mission's workers and the hospital psychiatric clinic.

Referral for Psychiatric Help by the Mission and Some Other Agencies

Referring again to Table V, it was shown thirdly that two cases were referred for psychiatric help by the Mission and other agencies on different occasions. In the case that follows it is shown how different referrals can be made at different times by different agencies.

> Phyllis (10) was born in 1931. She was referred to the Mission in 1943 when she was twelve years old with a diagnosis of rheumatic fever and rheumatic heart disease, and placed in a convalescent hospital. She was a high-strung child, difficult to restrain, who came from a crowded, emotional, noisy home with seven children. Her disposition was cranky. Her father was of Scotch descent and her mother was French. The mother dominated the family with her continual sharp criticisms as if she were too neurotic to be able to show any softness or affection. The other children appeared somewhat immune to her scoldings with Phyllis being the most sensitive. In the hospital Phyllis showed a terrific temper and rebelled against the authorities. During this period she ran off a few times in the middle of the night and had to be brought back from the woods. The staff of the hospital became upset at this time about Phyllis's father. They said that whenever he visited her alone he would sit on the bed with his arms around her and kiss her with more than fatherly affection, which she reciprocated. She was very disappointed

at having to stay in bed and made several unsuccessful attempts at getting up. Contrariness became more pronounced as she quarreled with the children and frequently refused to eat. She developed fears, particularly in connection with death and with men coming in her room at night. Phyllis did not respond much to efforts to help her. The doctor advised moving her to a foster home as he thought that her emotional difficulties were interfering with her recovery.

Phyllis was moved to a medical foster home in February, 1944. She made a better adjustment there. Her doctor tried to get her up for psychological reasons as she still reacted with great disappointment to being on bed rest. However, swelling or pains in joints or eye infection made it necessary for her to go back to bed. In October she ran away from the foster home in the middle of the night. She was trying to reach her home, but asked to be returned to the foster home when picked up by a policeman on a bus. Although she revealed little about this episode, it was learned from the other girls that she threatened to run away and jump out of the window previously and had just had a quarrel with one of the girls who, she felt, picked on her.

Early in 1945 she went home under supervision of the Mission. She was followed medically by an hospital in her community.

Her doctor felt she should be seen in their psychosomatic clinic. She was seen once in December, 1944, and no more until 1945 when she was seen a few times. Her doctor had recommended to the worker that she be encouraged to verbalize her resentment against her illness. In August, 1945, she went out with a soldier and there was a possibility that she had sexual relations with him. She showed no signs of guilt. Her doctor felt that more psychiatric help was needed, but no doctor was able to see her at the hospital. She wore too much makeup and was very interested in boys. Her parents were afraid to give her much freedom causing Phyllis to be resentful. In February, 1946, she ran away and was found by police sleeping in an empty warehouse. She said she was on her way to the foster home where the worker had taken her to visit recently. The mother admitted that Phyllis had run away after one of her spells of defiance.

The eldest sister had just run off to be married against the permission of her parents. The worker arranged for Phyllis to stay a week in the foster home. Phyllis complained that her parents were too strict. The worker was able to arrange for Phyllis to be seen at a psychiatric clinic. However, the mother refused to let her go, although by that time the worker had obtained a good relationship with this family.

A good year followed for Phyllis. The worker tried to encourage her mother to allow her as much wholesome relation-

ship with boys as possible. The mother felt that her activity at the church was sufficient and she still felt no need for psychiatric help.

While Phyllis was living at home, the case was kept open in order to give her some support. However, in 1947 she appeared in court. She was finally referred by the court to a child guidance clinic and was accepted there for treatment in July, 1947.

The social worker cooperated with that agency in helping Phyllis use the treatment adequately.

As in this case, when the children were referred either by the Mission or by other agencies, the worker always used the psychiatric help by cooperating with the psychiatric agency giving this help. This cooperation will be discussed more fully later.

Referrals for Psychiatric Treatment by the Mission

The last point to be considered in Table V is the actual referral of children for psychiatric help by the workers of the Mission. Table V shows that the largest number of referrals, that is to say 14 out of 23, were made by the workers of the Children's Mission directly to psychiatric clinics. The procedures of referral will be discussed here, before examining certain specific aspects of the use of psychiatric help by the Mission.

When the workers found sufficient evidence of a need for psychiatric help in a child, they referred him to a psychiatric agency. Generally, the choise of this agency depended on whether the hospital where the child was being followed medically had a psychiatric clinic or not. If so, this agency was contacted in preference to the others. The psychiatric agency chosen was contacted and written a full summary of the

Mission's contact with the child and of his traits and personality.

With the exception of consultations with private psychiatrists, the services offered to the children of the Mission were given free of charge in the clinics unless the parents were able to pay part of the treatment. The workers usually took the children to the clinics from their foster homes or their homes. Sometimes the foster parents or the parents would take the children to clinic. But generally the first alternative was preferred as it gave the workers a chance to know the children better, to keep a close contact with the psychiatric agencies and to observe the children's reactions to the treatment.

The workers of the Mission usually interpreted the necessity of psychiatric treatment to the parents and worked with them in order to obtain their cooperation. However, it was sometimes impossible or not advisable to notify the parents because they were mentally too deficient to understand such treatment or, as was the case for Lorette, because the parents were living at such a distance that the worker felt it might worry them to know about it by letter because they could not speak English. This is the case of Lorette (7).

> Lorette was placed in a medical foster home by the Mission in July, 1948, when she was eight years old. She was followed medically at the hospital for arthritis. This foster home has a capacity for fourteen girls of all ages, most of whom are convalescing from rheumatic fever. Despite the medical routine of bed rest, gradual time up, temperature and pulse taking, medication taking, the atmosphere is not institutional but homelike with a motherly foster mother. Lorette was put in with about five of the younger children near her age. Lorette had readily accepted the idea of placement in a calm, nonchalant way. Once placed, however, she showed signs of homesickness although she seemed to like the home. It soon became obvious that she was upset because her family were not visiting. She

wrote letters playing on their sympathy so that the parents became worried and the Mission was glad to cooperate with the Department of Public Welfare of the locality in arranging for the mother and sister to visit Lorette. This visit seemed to relieve Lorette's illness.

She related easily to both children and adults. She was really a delightful child with a surprisingly grown up air and a sense of humor. She did not hesitate to take the blame for anything she had done and she did not mind being corrected.

She did not, therefore, present any problem in the foster home. However, there were certain personality traits which led the worker to feel that there might have been some emotional disturbances going on. In the first place, Lorette's incessant chattering was very noticeable. Imagination was so active that it was difficult to tell sometimes how much was truth, how much fantasy. In the beginning especially she talked a great deal about hospitals, doctors and operations. In connection with this she spoke about sticking and being stuck with needles and knives and would place scissors at her throat or stick pins through her skin. It was evident that she missed the attention of the doctors in the hospital and she openly spoke of flirting with them.

The few times she went to the clinic, she became visibly excited, particularly the first time back when she cried out as she approached the hospital, "It tempts me, it tempts me." She was disappointed to be seen by only one doctor.

While being examined she acted subdued and was very good at the dentist's although she had never been before.

Another topic of conversation was marriage and boy friends. She spoke of boy friends both with children and adults at home and at the hospital. Besides being interested in everyone's marital status, she would take her teddy bear or doll to bed with her as her husband. She could play house for hours with the two other children near her age. She was usually the leader and the mother and they acted out medical examination.

She mentioned her large family often as if everything were harmonious, although the foster mother thought she might show some resentment toward one of her brothers. She had eight siblings. She classified herself as a tomboy who was interested in boys' games.

The question of psychiatric help came up when Lorette swallowed a bobby pin, and then cut off her eyebrows about two weeks later. She swallowed the bobby pin while lying in bed, but the worker thought it must have been a difficult thing to do. She acted excited rather than frightened about being rushed into the hospital emergency ward and later being brought to the clinic. She was referred to the psychiatric clinic in December, 1948, by the worker and was accepted for treatment.

Since then she has been regularly to the psychiatric clinic.

As said before in this case, the parents were not informed of the psychiatric treatment. The worker felt it was better to wait until the parents visited to explain to them the reasons for the referral. However, such a case was quite an exception and usually the parents were told about the psychiatric treatment and often cooperated with the worker of the Mission and the psychiatric clinic. In some cases, the psychiatrist felt that it was essential that the parents should be seen as well as their children. This happened more often when the children were living at home under the supervision of the Mission's worker. In such cases it was usually the worker of the Mission who first tried to include the parents in the treatment of their children as she already knew the family. According to the degree of relationship between the worker and the parents, it was decided whether the social worker of the psychiatric clinic should step into the picture or not, and whether she should try to develop a case work relationship with them.

Cooperation of the Mission with Psychiatric Agencies

As demonstrated above, there was always close cooperation between the social workers of the psychiatric agencies and the Mission. The workers helped each other with case histories. The Mission's workers had conferences with the psychiatrists and followed closely the development of the psychiatric treatment of the child. They used the recommendations of the psychiatrists and provided them with useful material as it came to their attention. This cooperation of the workers with the psychiatric agencies is well illustrated by the following case.

Arnold (23) was referred to the Children's Mission in 1945, when he was ten years old with a diagnosis of rheumatic fever. The Mission had a record of the family background already since two attempts to place Arnold in a medical home in 1941 did not go through, once because of his resistance and a second time because of his becoming acutely ill with rheumatic fever and rheumatic heart disease.

His mother seemed to have the lowest standards and was in constant conflict with the father's family of higher grade. However, the father had a marital history of frequent non-support and drunkenness for which he was sent to jail a couple of times. The family was frequently on public welfare with a report of mother being a poor manager.

The mother dates the onset of Arnold's disturbing behavior to the period when he was six. At that time, a brother Anthony was born and the parents were separated for a few months. It was also the period of his first attack of rheumatic fever.

Arnold was an unattractive boy whose head seemed too large and whose mouth was misshapen from the absence of several front teeth lost in a fall. At six years of age he was an overactive, scrawny child with restless, erratic behavior. He was placed with maternal relatives several times, but he seemed to want to be with his mother. He used to sleep with her. In 1945 he was placed by the Mission in a convalescent hospital. There he was a shy, sensitive boy, apparently insecure. His mother visited only infrequently. He got along fairly well with the group. He was tested (Binet) and found to be in the upper normal group. His school work was satisfactory. When he was ready to go home and the worker prepared him for his return home, his feelings about it were unfathomable, but he hung his head and refused to talk when the possibility of placement in a foster home was brought up. He showed, however, a very negative reaction once home. He resisted any health or disciplinary control by his mother by exhibiting infantile behavior such as crying, screeching, stamping, biting, hitting and sitting on the floor. He also told his mother she did not love him and was mean. Although he had an enormous appetite, he accused her of not giving him enough to eat. He took neighborhood boys in the house to feed when his mother was out. He cashed all bottles he could get his hands on and once collected money by lying that he was doing it for the newsboy. He apparently joined in with other boys. A number of times he had threatened to run away and most recently when he was threatened with being demoted. He was reluctant to attend school and was doing poor work in the fourth grade. He seemed to be too quiet and expressed the feeling that the other children were watching him and making him nervous.

The mother's methods of discipline were poor, consisting largely of impatient demands and threats although she agreed to nag him as little as possible. She was willing to accept guidance for him and herself even though at times the worker suspected that she would like to be relieved of his care. While she was a friendly person, her mental capacity for treatment was questionable. The worker's contact with her had shown her to be exceedingly unstable and vascillating. The father at that time came back from the services and Arnold was better when he was around.

The case was discussed in July, 1946, with the consultant of the Mission who strongly recommended psychotherapy with a man psychiatrist as soon as possible. Previously, in November, 1945, the worker had referred him to a child guidance clinic where he had been accepted for treatment. This happened seven months after his referral to the Children's Mission. Unfortunately, the mother refused to cooperate with the clinic. The worker tried to have her understand the necessity for it, but she was unable to give Arnold any acceptance. She identified the boy with his alcoholic, abusive, non-supporting father who had a period of psychiatric observations following attempted suicide. The boy was at that point very immature and insecure, seeking refuge with his mother, which he could not obtain from her.

The mother finally accepted the treatment and Arnold was seen by a man psychiatrist. As the worker had supervised this child at home, she knew the mother well. She was able to give very valuable information to the clinic. She worked closely with the social service of the child guidance clinic. As the mother was reluctant to cooperate with the psychiatric clinic, she was in the position to influence her towards more acceptance of the boy. She also worked closely with the psychiatrist who saw Arnold regularly during the following years.

It was shown in this case how the case worker from gathering this boy's social history and emotional development and from her contacts with him was able to detect signs of emotional disturbance needing psychiatric treatment.

Also, it was demonstrated how the worker cooperated with the social service of the psychiatric clinic and with the psychiatrist.

Cooperation with Psychiatric Clinic and Other Agencies in Order to Restore Mental Health in Families

Close cooperation was sometimes obtained not only with the psychiatric agencies but with other agencies as well. For, as a result of the psychiatric difficulty, it sometimes became necessary to take further steps to help a family out. This required the cooperation of different agencies who helped the family in their respective area and realized a common plan for the welfare of each member. This was illustrated by the case of Janet. In the case of Janet (5), her emotional needs were so great and her need for a family life so essential that everything possible was done to bring together several agencies to restore a normal situation.

> Janet (5) was seven years old at the time she was placed by the Children's Mission with a diagnosis of asthmatic bronchitis. Her father had died the previous year after a long and painful illness. Her mother had been very unhappy about it and did not recover from this loss. There were three other children in the family and the financial struggle was great. The mother was extremely nervous and developed hysterical paralysis. She attended a psychiatric clinic. The mother was most anxious about Janet's attacks and the worker suggested that the mother's solicitous manner contributed to Janet's illness. The child was oversensitive and the tiny suggestion that she was naughty would make her crumple up in tears. After nearly a year in the foster home, Janet was discharged to her mother but was replaced after two months as her mother became ill.
>
> Janet was very withdrawn when she was in her own home. She was in a state of withdrawal, had fears of violence, of wild animals and of death.
>
> After a consultation with the Mission psychiatric consultant in 1945, the worker understood that back of the mother's capability and ability lay rejection. In January, 1946, the consultant suggested psychotherapy. It was clear at that time that the mother's reaction was a result, at least in part, of all she went through when the father was ill.
>
> In February, 1946, nearly two years after Janet was first referred to the Mission, a conference was held between the

workers of public and private agencies of hospitals and of the Mission. As the result of this conference, it was eventually worked out that the public agency would pay for the medical care of the mother while she was at the hospital, the private agency would send a housekeeper when the mother returned. The maternal aunt had taken care of the children while the mother was away with the exception of Janet who was placed with the Mission under the medical care of the local hospital.

In April the same year she was referred to the city hospital for psychotherapy. The emotional needs of Janet and the psychogenic elements of the cause of her illness were not only recognized, but the treatment was provided.

In August Janet was able to go home on home supervision. She continued to receive psychiatric help during 1947 and 1948 and obtained excellent results.

The Children's Mission, with the valuable cooperation of other agencies who knew the family and who relieved the financial tension, helped this mother and child to get psychiatric care which might eventually result also in a better physical health.

Family Factor

From the study of the twenty-three cases described in Table V, it was a common feature to notice that the families of those children were usually below normal standard and incapable of giving the children proper care and offer them healthy emotional ties. In many cases there was marital friction, the parents were using or in need of psychiatric treatment themselves. Several parents appeared to be schizophrenic, paranoid, neurotic. A considerable number of the fathers were drinking heavily and non-supporting. Many mothers were rejecting and punishing or, on the other hand, over-protective and dominating. As a matter of fact, all of the families of the twenty-three cases studied, showed evidence in one way or another of the above disturbances.

Psychosomatic Factor

Considering this fact, it was not surprising that several children of the group had developed psychosomatic symptoms, although in many cases it was hard to differentiate between psychosomatic illness and others. The study of the whole group of children showed clearly that the family situation was largely contributing to the onset of diseases. Some cases were clearly psychosomatic and were treated as such after referral by the Mission's worker. Here are two cases illustrating psychosomatic illness in children and showing how the worker recognized their need for psychiatric help and how she referred them to appropriate psychiatric agencies.

> Emily (2) was a state ward. She had a dorsal lumbar scoliosis and had to wear a brace. She was referred to the Children's Mission when she was fourteen because she was a medical problem. While in the care of the public agency, she had frequent constipation. For eight years she had had violent temper tantrums and the foster mother had been advised to throw cold water at her face to calm her. She had been placed with her sister and had been unusually violent toward her, biting and beating her. She was anxious and guilty over the things she did to her sister. She was good at school.
>
> She was placed in a medical foster home by the Mission. She was sleepless, had constant nightmares. She usually dreamed that a lady came to take her away. Sometimes it was a man and she was thrown out of the window breaking her back. A very common dream was the one of falling off a curb. She had much anxiety about her constipation. The worker started giving her some sex information when she realized that Emily still believed that birth occurred from the stomach. Natural bowel movements began after Emily's clarification on sex matters. She had enuresis. She was afraid of the prospect of returning to the state. The worker referred her to a child guidance clinic on December 2, 1947, but she could not be seen before spring. In January she developed an hysterical kind of blindness and the eye specialist thought it was the result of her unconscious blacking out of things in time of disturbance. Under the circumstances the worker referred her

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She was placed in a medical foster home by the Mission. She was sleepless, had constant nightmares. She usually dreamed that a lady came to take her away. Sometimes it was a man and she was thrown out of the window breaking her back. A very common dream was the one of falling off a cliff. She had much anxiety about her constipation. The worker started giving her some sex information when she realized that Emily still believed that girls acquired from the stomach. Natural bowel movements began after Emily's clarification on sex matters. She had enuresis. She was afraid of the prospect of returning to the state. The worker referred her to a child guidance clinic on December 8, 1947, but she could not be seen before spring. In January she developed an hysterical kind of blindness and the eye specialist thought it was the result of her unconscious blocking out of things in view of disturbances. Under the circumstances the worker referred her

again to the guidance clinic, but again she was turned down and this time there was no hope for her to be seen before the fall. The psychiatric clinic of a hospital was suggested. She was referred to this agency and obtained her first appointment in February, 1948. The next month she had to be discharged from the Mission to the public agency, as her symptoms disappeared. She continued the psychiatric treatment at the hospital with close cooperation between the workers of the public agency and the Mission.

Another case of evident psychosomatic illness was the one of Carlo (19), the youngest child of a family of eleven children. He had a diagnosis of asthma. He was referred when he was sixteen years to the Mission for placement by a boys' parole board. He had been in a delinquent home intermittently since he was eleven, originally being committed for breaking and entering, but lately being returned because of his health. The psychiatrist of this institution recommended placement. As the boys parole board did not maintain medical homes, he was turned over to the Children's Mission. While the Mission recognized the likelihood of a serious case of asthma, medical information seemed to imply that he could function in a decent environment. The worker further recognized the real possibility that a boy who had lived most of his last five adolescent years in an institutional setting might experience real difficulty in making an adjustment to the greater demands of a foster home setting. Although the Children's Mission had homes with groups of children, the worker felt in view of his delinquent background that it was not fair to the other children to put him in such a place. The impossibility of a return to his own home was definitely shown by the poor family situation found in the boy's parole record.

Therefore, the worker sought a proper home and after considerable difficulty located a colored foster home with a strong, mature, older woman who had had experience with asthma. Carlo wanted to try it. He reacted within the first ten minutes of meeting the colored foster mother with stomach symptoms. He lasted with her a little over a day and two nights, when she hospitalized him as a result of the consistency and frequency of his attacks.

He was discharged from the hospital to the Mission. He was placed for what was hoped would be a period of study with white foster parents, but he so upset their household with the frequency and violence of his attacks that he was hospitalized two days later. The foster parents refused to take him back. These people also had had successful experiences with asthma patients.

At this point, the medical director of the Mission requested that he should be held at the hospital for observation since indications were that he could not manage in a foster

> home under heavy medication but did well in the hospital with a minimum. However, the hospital discharged him and the Mission put him with a nurse and made this very evident to him, which seemed to give him some security. Still it was the same thing. Although he was heavily injected with adrenalin, he was convinced he was dying in the foster home. A police cruiser rushed him to the hospital at 4 a.m. and when the worker saw him about ten minutes after his admission he did not have a wheeze. At this point, the hospital agreed to admit him for study. The worker had a consultation with the psychiatrist who advised the best plan for him after seeing him.

In this case, the worker was immediately aware of the psychomatic symptoms of the boy. According to her findings she tried to help the boy to adjust in the foster home she had carefully chosen for him. She developed a good relationship with him, but his symptoms were too deeply rooted for him to benefit from it at this point. If this child had been referred earlier he might have been able to adjust in a foster home.

At this point he could only adjust in the hospital or the institution. He went back to the latter. It is interesting to stop a while and consider the findings of the psychiatrist about this boy while he was in the hospital.

"From observation on the ward and from psychotherapeutic interviews, we got the impression that emotional factors play a decisive role in Carlo's asthma attacks."

> It seemed that he was very much attached to his mother and felt that he was the favorite child. This close attachment apparently was pleasant as well as threatening to him and in his early teens he apparently made an attempt to debauch himself, to become more grown up and more masculine. This he did by identifying with his brother, sharing aggressive and delinquent activities and worshipping guns. According to him these delinquencies were the first activities he kept as a secret from his mother to whom he otherwise used to confess his sins. It was felt that his guilt feeling for his

> aggression and the need to keep it from his mother, which he felt he should confide to her, was one of the conflicts contributing to the asthma, the more so as he knew his mother had a pulmonary disease and might die, which increased this anxiety and his guilt feelings. The confinement in the delinquent home aggravated his pain of separation from the family and his conviction that he is a bad boy who has to be put away. At the hospital he also complained during the first days about his isolation, but was reconciled when told he might go back to the institution. He has been free of asthma the last week. He himself has noticed that when he starts wheezing it helps him if he can talk to a person whom he trusts or even if he can read, but that it develops into an attack when he thinks he is going to be bad and he might die.

This report shows how this child needed psychiatric help when the worker requested a psychiatric study at the hospital.

If this case shows that little can be done without psychiatric help when it is already too late and the patient has developed serious illness, the following case will show that when there is still time to help a patient with emotional difficulties, it is not always easy to secure this help.

Length of Time to Obtain Psychiatric Help

In general, by considering the twenty-three cases using psychiatric help during 1947 and 1948, it was shown that when a case was referred for psychiatric treatment this help was received fairly quickly. From the date of referral to the first appointment received, the lapse of time differs generally from a week to a month. The psychiatric clinics of hospitals were usually quick to answer at referral. Seldom was it turned down.

Agencies used for Psychiatric Help

The psychiatric clinics of hospitals were most used by the Mission. Among the twenty-three cases referred for psychiatric help, twelve were referred to hospitals. Usually, the hospitals were ready to help a child who had a question of psychosomatic symptoms. On many occasions did the workers of the Children's Mission cooperate with this agency.

TABLE VI

TYPE OF AGENCY TO WHICH REFERRED

Child Guidance Clinic	6
Psychiatric Clinic of a general hospital	12
Both at different occasions	4
Private	1
	23

The child guidance clinics were much slower in answering a referral, this being mostly due to the fact that they have very long waiting lists. Usually, when a case was accepted by such an agency it took months to obtain the first appointment.

The following case was quite exceptional as it was referred five times to three different agencies. Encountering refusals to accept the case, the worker who saw the need of treatment for the child, had to show much conviction in applying twice to two different agencies. However, it took five months finally to obtain an interview from a child

guidance clinic.

But at this time it was already too late and there was a recurrence of rheumatic fever that the worker had feared. He was hospitalized and was accepted at the hospital's psychiatric clinic.

> Walter (20) was admitted at the hospital for rheumatic fever when he was seven years old. He had then considerable heart disease. He was a problem child and because of his violence had to be isolated. His I.Q. was 104. He was transferred to another hospital two months later and he stayed there for a year. He was then transferred to a convalescent home. There he was rude, disagreeable, contentious and fought viciously.
>
> An application to the Children's Mission at this time was not completed by the parents so he went home where he had poor health until December, 1946, when he was thirteen years old. At this time, his father applied to a private agency for help, having been referred there by the child guidance clinic. Walter had been before the court on two charges of breaking and entering. The court placed him on probation to a school for delinquents. He continued to truant and the school principal recommended his placement where Walter's two year school retardation would not upset him. Before this action was taken, Walter was picked up on a larceny charge in January, 1947. Shortly after that Walter was placed in the study home of a private agency. He then developed rheumatic fever and was referred to the Children's Mission for convalescent care.
>
> The Mission's experience with him was that he did not adjust very well. He greatly resented the loss of his male social worker at the private agency. He once told the worker of the Mission that his illness was a punishment for his delinquency. He was hospitalized a month in May, 1947. Since he acted so badly at the hospital, they insisted on his removal. He went home and was followed by a clinic. This hospital suggested that he attend their psychosomatic clinic and he was seen in January, 1947.
>
> In September, 1947, he was placed again by the Mission referred by the hospital. He ran away to his home two weeks later. At this point the former worker left the agency and he got a new worker. This worker referred him to the child guidance clinic in January, 1948. But this agency suggested the hospital's psychiatric clinic since they did not have a clinic with psychotherapy free for children with psychosomatic difficulties.
>
> Two months later he rang a fire alarm and was put on probation. He was also a truant from school. The worker again

referred him to the child guidance clinic, since Walter was a behavior problem, but he was turned down again. Meanwhile, the hospital also refused to consider him because he was delinquent.

The worker referred him to another hospital, but he was not accepted because of a lack of staff. At this time his behavior became more definite. He hated policemen, doctors, anyone who forced him to do things. He admitted some aggression toward his brother Bob and his father who beat him. But he felt he should like him. He hated his weakness because he was afraid of the consequences in his environment. He despised the years he had spent in bed and wished to be strong like other boys so he could protect himself. His father showed great aggression toward Walter who had through the years evicted him from his bed with mother. This was the method of controlling his enuresis. Walter was very attached to his mother who did not refrain from sleeping with him against the advice of the worker. She was soft with him in a way, but admitted having strapped him, and Walter told the worker she advised his brother Bob to beat him. The parents were constantly ill and complaining. The mother usually threatened Walter, telling him that if he did not do what she said, she would have a heart attack. The house was filthy.

In May, 1948, the worker referred him to the child guidance clinic. He was accepted and seen once but he got a recurrence of rheumatic fever and was hospitalized. This clinic finally accepted him for psychiatric treatment.

A last question that might be considered is What Happened to the Children While Waiting for Psychiatric Treatment?

The consideration of the cases illustrating this chapter answers the question. Indeed, it was clearly shown how the workers became aware of the particular emotional disturbances of medically handicapped children and how they recognized the need for psychiatric treatment for some of them. While they referred such children to psychiatrists, they kept a close relationship with the children and according to their knowledge and skills they handled the children's environments and offered them emotional support. While waiting to receive psychiatric treatment thus, the children were helped to handle their problems by

the case work support.

Generally, this support kept them from becoming more seriously ill. However, in one case in which the psychiatric treatment took several months to be granted, the referrals were finally accepted when the court referred a child to the child guidance clinic after she became delinquent. Another case of a child who did not handle his situation satisfactorily while waiting for psychiatric help was the one of an adolescent boy who had psychosomatic asthma and had to be brought to the hospital in emergency before receiving psychiatric help.

Those two cases were the exception, however, and the other twenty-one children were able to handle their difficulties without aggravating them. As mentioned earlier in this chapter, it was rarely more than a few weeks before the psychiatric treatment was obtained.

CHAPTER V

CONCLUSIONS

The purpose of this study was to consider the use of psychiatric help by a social agency without any psychiatric consultant on its staff. The agency chosen for the study was a medical child placing agency, the Children's Mission to Children. It was felt that a review of the history and function of the Mission would show the work done through the years with medically handicapped children and the interest of the staff in their emotional disturbances. It was shown how the Agency gradually adopted a definite policy of placing only medically handicapped children. Therefore, a special chapter was devoted to a discussion of particular factors involved in working with these children and of special skills needed by the social workers. The knowledge of emotional factors and psychosomatic symptoms helped the workers to deal with medically handicapped children. Not only did they need to recognize such symptoms, but they had to be able to foresee their onset. Whether the workers saw the children in their own homes or in foster homes, they needed to help the children adjust to their environment and the environment adjust to the children. If the social workers were skillful enough and if they did not meet too much resistance, they obtained the adjustment desired and avoided the danger of abnormal reactions.

The children needing psychiatric help at the Children's Mission during 1947 and 1948 came from a particularly poor environment. All but seven of the twenty-three children considered were over eight years old and their problems were already deeply rooted in many years of

frustration and misunderstanding. This explains why some of the children cared for by the Children's Mission were in desperate need of such help. How the Mission provided that help was described in Chapter IV.

First, the question of referrals for consultation of the worker with a psychiatrist was considered. It was explained that in the years preceding 1947 and 1948, at certain times, the Mission had had a psychiatric consultant on the staff so that such consultation was used constantly. The departure of the psychiatric consultant from the Mission was evidently a great loss as the need for such consultation is particularly great in a medical child placing agency. The appointment of a psychiatrist on the staff of a social agency is an expensive process. A more suitable solution would be greater opportunities for obtaining consultation services in psychiatric agencies. Here lies the responsibility of such agencies in the community.

Next were discussed the actual referrals to a psychiatrist; referrals by agencies other than the Mission; referrals by other agencies together with the Mission on different occasions; and finally, the most frequent ones, by the Children's Mission alone.

In each instance, the need of psychiatric help was evident. The children who obtained this help, if not mentally ill, were on the verge of becoming so. Nowadays, when the need of psychiatric help is so great and the opportunity of securing it so limited, it is almost impossible to obtain it on a simply preventive basis, because all the efforts are centered on the acute problem. The preventive treatment is still more or less entirely in the hands of the social workers. In the clinics

generally there is such a demand that only the most serious cases are considered. In private practice, the psychiatrists accept patients on a preventive basis more frequently than in the clinics. Patients who cannot afford private treatment seek then the help of social agencies. Also, there is a need for more consultation opportunities. It is the hope that in the future, clinics will expand their services of psychiatric consultation services to social and welfare agencies.

When the workers recognized the need for psychiatric treatment of children under their care, they helped the children and their family accept the idea of referral to a psychiatrist. The agencies to which the children were referred were cooperative. They usually accepted the children referred to them, although in some cases the psychiatric treatment was frequently refused on account of long waiting lists. The procedures of referral were discussed and several examples were given in this study. It was shown by such illustrations how the workers became aware of the need of certain children for psychiatric treatment and how they offered them case work support.

Also, the contact with the psychiatric agencies was described. The cooperation of the different staff members was usually very close. Also, it was made evident that the work of the Mission included case work with the families of the children. Although occasionally the worker was instrumental in obtaining psychiatric treatment for some member of the family other than the child under care, this aspect of the use of psychiatric help was not considered in this study. However, in securing psychiatric help for the children, the cooperation of the parents was

needed, and this was pointed out in the case illustrations.

In some cases, the cooperation of other social agencies was obtained and a plan was worked out to help the family efficiently. It was shown that although one may work within the structure of one's specialty -- family case work, children's welfare, psychiatric social work, medical social work, medicine, psychiatry, and so on -- the real concern of mental hygiene is the integration of all these elements. It was within the constellation of all services and skills that the best results can be obtained.

In all the steps taken by the social workers of the Mission, it was evident that appropriate skills and unusual ability was needed.

As the science of social work grows, the skills required from the social workers will increase. No longer is it sufficient to have merely the desire to help as growing knowledge is necessary. But on the other hand, although the understanding of social work has grown, the original charitable impulse must retain all its strength and spontaneity.

Approved,

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APPENDIX

Schedule Used to Serve as a Basis for Analysing Cases Studied in Full

NAME

AGE

SEX

DIAGNOSIS

REASON FOR REFERRAL

REFERRED FOR CONSULTATION OR TREATMENT

AGENCY REFERRED TO

REFERRED BY

LENGTH OF TIME TO OBTAIN PSYCHIATRIC HELP